Complete Summary

GUIDELINE TITLE

The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge.

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians & Gynaecologists, British Association for Sexual Health and HIV. The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. J Fam Plann Reprod Health Care 2006 Jan;32(1):33-42; quiz 42. [42 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Vaginal discharge
- Bacterial vaginosis (BV)
- Vulvovaginal candidiasis (VVC)
- Sexually transmitted infections caused by Trichomonas vaginalis (TV, trichomoniasis), Chlamydia trachomatis, or Neisseria gonorrhoeae

GUIDELINE CATEGORY

Diagnosis
Evaluation

Management
Treatment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To provide evidence-based recommendations and good practice points on the management of women of reproductive age complaining of vaginal discharge who attend non-genitourinary medicine (GUM) settings (where near-patient microscopy is unavailable)

TARGET POPULATION

- Women of reproductive age complaining of vaginal discharge

These Guidelines are not intended for use in the following patients:

- Children
- Postmenopausal women

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Consideration of infective and other causes for vaginal discharge (e.g. foreign body, cervical ectopy)
2. Clinical and sexual history to assess symptoms and risk factors
3. Use of point-of-care investigations, including physical examination and measurement of vaginal pH
4. Liaison with local laboratory on specimen processing and information provided
5. Lab investigations including endocervical or high vaginal swabs, microscopy, gram stain, culture, nucleic acid amplification tests, and nucleic acid hybridisation tests

Treatment/Management

Non-sexually Transmitted Diseases

1. Oral or vaginal metronidazole, clindamycin, or tinidazole for bacterial vaginosis (BV)
2. Advising women using combined hormonal contraception to use additional contraception protection (e.g. condoms) during the antibiotic course and 7 days afterwards
3. Oral, vaginal, or vulval antifungals (azoles) for vulvovaginal candidiasis (VVC)
4. Advising women that latex condoms, diaphragms and cervical caps may be damaged by some vaginal/vulval antifungal treatments
5. Use of probiotics (live yoghurts) in the management of VVC or BV
6. Testing and treatment of the male sexual partner(s) for VVC or BV (considered, but not recommended)

Sexually Transmitted Diseases (STIs)

1. Oral metronidazole for trichomoniasis vaginalis
2. Treatment of Chlamydia trachomatis and Neisseria gonorrhoeae infections according to national guidance
3. Partner notification and treatment of sexually transmitted diseases

Special considerations for women during pregnancy, post-partum, post-abortion, and for recurrent infection

Note: Routine screening for Trichomonas vaginalis in pregnancy was considered but not recommended.

MAJOR OUTCOMES CONSIDERED

- Sensitivity, specificity, and utility of diagnostic tests
- Initial cure rates
- Relapse rates

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Electronic searches were performed for: MEDLINE (CD Ovid version) (1996-2005); EMBASE (1996-2005); PubMed (1996-2005); The Cochrane Library (to February 2005) and the US National Guideline Clearing House. The searches were performed using relevant medical subject headings (MeSH), terms and text words. The Cochrane Library was searched for systematic reviews, meta-analyses and controlled trials relevant to vaginal discharge. Previously existing guidelines from the British Association for Sexual Health and HIV (BASHH) and the Faculty of Family Planning and Reproductive Health Care (FFPRHC), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization, the Department of Health, the British Medical Association, the Royal College of

Nursing, the Royal College of General Practitioners and reference lists of identified publications were also searched. Similar search strategies have been used in the development of other national guidelines.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Not Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected key publications were appraised according to standard methodological checklists before conclusions were considered as evidence. Evidence was graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organisations.

Evidence tables are available on the Faculty of Family Planning and Reproductive Health Care (FFPRHC) website. These summarise relevant published evidence on use of contraception outside product licence, which was identified and appraised in the development of this Guidance.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A Evidence based on randomised controlled trials (RCTs)

B Evidence based on other robust experimental or observational studies

C Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the expert group

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the grades of recommendation based on levels of evidence (A-C, Good Practice Point) are provided at the end of the "Major Recommendations" field.

What are the commonest causes of vaginal discharge in women of reproductive age?

1. In women of reproductive age complaining of vaginal discharge the commonest cause is physiological, but infective and other causes (e.g., foreign body, cervical ectopy) should be excluded (Good Practice Point).

Refer to Table 1, "Causes of vaginal discharge in women of reproductive age" in the original guideline document for additional information.

Why is it important to take a clinical history from a woman complaining of vaginal discharge?

2. A clinical history (to ascertain associated symptoms) and a sexual history (to assess sexually transmitted infection [STI] risk) can guide a clinician in the further management of a woman with vaginal discharge (Grade B).
3. A clinician should ask a woman: how her discharge has changed; what she is concerned about; whether there is any odour or itch; whether there are any symptoms suggestive of upper reproductive tract infection (i.e., pain, dyspareunia, bleeding) and should assess risk of STIs (Good Practice Point).

4. Risk factors for STIs to be sought are: age <25 years; change in sexual partner in the last year; more than one partner in the last year (Grade B).

When should a woman complaining of vaginal discharge be investigated?

5. A woman of reproductive age complaining of vaginal discharge should be investigated if: she requests investigation; she is deemed to be at higher risk of STIs; there are symptoms indicative of upper reproductive tract infection; previous treatment has failed; she is postnatal, postmiscarriage or post-abortion; or she is within 3 weeks of intrauterine contraceptive insertion (Grade C).
6. A woman of reproductive age presenting with vaginal discharge who is low risk for STIs and without symptoms indicative of upper reproductive tract infection may be given empirical treatment, based on symptoms, without taking swabs at first presentation (Grade C).

Refer to Figure 1, "Flow chart for the assessment of women attending non-genitourinary medicine settings complaining of vaginal discharge" in the original guideline document for additional information.

What point-of-care investigations can be performed in non-genitourinary medicine settings?

7. Together with symptoms and signs, assessment of vaginal pH aids the clinician in the management of a woman complaining of vaginal discharge (Grade C).
8. Vaginal pH can be measured on secretions obtained from the lateral vaginal walls using narrow range pH paper (Good Practice Point).

Refer to Table 2, "Summary of symptoms and signs (including point-of-care test for vaginal pH) associated with common infective causes of vaginal discharge in women of reproductive age" in the original guideline document for additional information.

What laboratory investigations can be performed on women complaining of vaginal discharge?

9. Clinicians should liaise with their local laboratory to find out how specimens are processed and what information they will be able to provide (Good Practice Point).
10. Clinicians should provide laboratory staff with appropriate clinical information when submitting specimens from women with vaginal discharge including: risk of STIs, suspicion of STIs and associated symptoms (Good Practice Point).

Refer to Table 3, "Summary of laboratory processing of specimens from women complaining of vaginal discharge" in the original guideline document for additional information.

Which treatments are appropriate for women complaining of vaginal discharge?

Treatment of non-sexually transmitted infections

Treatment of bacterial vaginosis (BV)

11. The recommended treatment for BV is oral metronidazole (400 to 500 mg twice daily for 5 to 7 days, or a single 2 g dose) (Grade A).
12. Testing and treatment of the male sexual partner(s) is not indicated (Grade C).
13. Women using combined hormonal contraception should be advised to use additional contraceptive protection (e.g., condoms) during the antibiotic course and for 7 days afterwards (Grade C).

Treatment of vulvovaginal candidiasis (VVC)

14. Vaginal and oral antifungals (azoles) are equally effective in the treatment of VVC (Grade A).
15. Vulval antifungals (in addition to oral or vaginal regimens) can be used if women have vulval symptoms (Good Practice Point).
16. There is no need for routine screening or treatment of male partner(s) (Grade C).
17. Women should be advised that latex condoms, diaphragms and cervical caps may be damaged by some vaginal/vulval antifungal treatments (Grade C).

Use of lactobacillus

18. Women may use probiotics (live yoghurts) in the management of VVC or BV but evidence of effectiveness is poor (Good Practice Point).

Treatment of sexually transmitted infections

Treatment of Trichomonas vaginalis (TV)

19. The recommended treatment for TV is oral metronidazole (a single 2 g oral dose or 400 mg twice daily for 5 to 7 days) (Grade A).
20. Women should be informed that TV is an STI and partner notification and treatment is recommended for all partners in the last 6 months (Grade C).

Treatment of Chlamydia trachomatis and Neisseria gonorrhoeae

21. Women identified as having an STI should be treated according to national guidance. Local integrated care pathways should be in place for testing for other STIs and for partner notification (Good Practice Point).

Partner notification

22. Patient treatment and partner notification can take place in genitourinary medicine (GUM) clinics, general practice or family planning services if staff have the appropriate skills (Good Practice Point).

How should clinicians manage women with vaginal discharge in special circumstances?

Vaginal discharge in pregnancy

Bacterial vaginosis (BV)

23. Pregnant women with BV should be treated as for non-pregnant women (Grade A).

Vulvovaginal candidiasis (VVC)

24. Women with VVC in pregnancy should be given vaginal azole regimens but may require up to 7 days' treatment (Grade A).
25. Women with VVC in pregnancy should avoid oral antifungals because of potential teratogenicity (Grade C).

Trichomonas vaginalis (TV)

26. There is no indication for routine screening for TV in pregnancy. However, treatment is indicated if TV is diagnosed (oral metronidazole 400 mg twice daily for 7 days) (Grade A).

Vaginal discharge following miscarriage, abortion or delivery

27. Women with vaginal discharge after miscarriage, abortion or delivery should be investigated at first presentation. Treatment for likely causal organisms may be appropriate while awaiting swab results (Good Practice Point).

Recurrent vaginal discharge

28. Consideration should be given to underlying causes in women presenting with recurrent vaginal discharge due to BV or candida (Grade C).
29. Clinicians should be aware of psychosexual problems and depression, which can occur in women with recurrent vaginal infections (Good Practice Point).

Recurrent bacterial vaginosis (BV)

30. For women with recurrent BV, suppressive regimens (outside the product licence) may be considered, but evidence to support their effectiveness is limited (Grade C).
31. Women can be advised to avoid use of douches, shower gels, antiseptic agents and shampoo in the bath (Grade C).

Recurrent vulvovaginal candidiasis (VVC)

32. For women with recurrent VVC (four or more episodes in 12 months) an 'induction and maintenance' regimen may be used for 6 months (Grade B).
33. Women can be advised to avoid douching, local irritants, perfumed products and tight-fitting synthetic clothing (Grade C).

Recurrent Trichomonas vaginalis (TV)

34. Recurrent TV is usually due to re-infection, but consideration should be given to the possibility of drug resistance (Grade C).

Refer to Table 4, "Medical treatments for common infective causes of vaginal discharge in women of reproductive age" in the original guideline document for additional information.

Definitions:

Grades of Recommendations

A Evidence based on randomised controlled trials (RCTs)

B Evidence based on other robust experimental or observational studies

C Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the expert group

CLINICAL ALGORITHM(S)

A clinical algorithm is provided in the original guideline document for the assessment of women attending non-genitourinary medicine settings complaining of vaginal discharge.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of women of reproductive age attending non-genitourinary medicine (GMU) settings complaining of vaginal discharge

POTENTIAL HARMS

- Latex condoms, diaphragms and cervical caps may be damaged by vaginal preparations containing econazole, miconazole, isoconazole or clotrimazole.
- Clindamycin intravaginal cream can also damage latex condoms.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Avoid alcohol with metronidazole therapy
- Avoid high-dose single regimens for treatment of bacterial vaginosis (BV) or Trichomonas vaginalis (TV) if breastfeeding
- Avoid antifungals during pregnancy because of risk of teratogenicity

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Clinical Algorithm
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Royal College of Obstetricians & Gynaecologists, British Association for Sexual Health and HIV. The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. J Fam Plann Reprod Health Care 2006 Jan;32(1):33-42; quiz 42. [42 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Jan

GUIDELINE DEVELOPER(S)

British Association of Sexual Health and HIV - Medical Specialty Society
Faculty of Family Planning and Reproductive Health Care - Professional Association

SOURCE(S) OF FUNDING

Faculty of Family Planning and Reproductive Health Care

GUIDELINE COMMITTEE

Clinical Effectiveness Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

Print copies: Available from the Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent's Park, London NW1 4RG

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Discussion points and questions for the management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. London (England): Faculty of Family Planning and Reproductive Health Care; 2006. 1 p.

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Family Planning and Reproductive Health Care Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 15, 2006. The information was verified by the guideline developer on May 19, 2006.

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